Nursing Supplies and Dressing (other than items of personal comfort or cosmetic)
Overhead Trapeze Equipment
Oxygen Equipment (such as IPPB Machines and Oxygen Tents)
Oxygen Mask
Pads
Peroxide
Pitcher
Plastic Bib
Pump (Aspiration and Suction)
Restraints
Room and Board (semi-private or private if necessitated by a medical or social condition)
Sand Bags
Scalpel
Sheepskin
Special Diets
Specimen Cups
Sponges
Steam Vaporizer
Sterile Pads
Stomach Tubes
Stool Softeners, Non-legend
Suction Catheter
Suction Machines
Suction Tube
Surgical Dressings (including Sterile Sponges)
Surgical Pads
Surgical Tape
Suture Removal Kit
Suture Trays
Syringes (all sizes)
Syringes, Disposable
Tape-For Laboratory Tests
Tape (non-allergic or butterfly)
Testing Sets and Refills (S & A)

Tongue Depressors
Tracheostomy Sponges
Tray Service
Tubing-I.V. Trays, Blood Infusion Set, I.V. Tubing
Underpads
Urinary Drainage Tube
Urinary Tube and Bottle
Urological Solutions
Vitamins, Non-legend
Walkers
Water Pitchers
Wheelchairs

Substitute per letter dated SEP 23 1998

Title 13 - DEPARTMENT OF SOCIAL SERVICES
Division 70 - Division of Medical Services
Chapter 10 - Nursing Home Program

13 CSR 70-10.080 Prospective Reimbursement Plan for HIV Nursing Facility Services

(1) Authority. This State Plan is established pursuant to the authorization granted to the Department of Social Services (Department), Division of Medical Services (Division), to promulgate rules and regulations.

(2) Purpose. This State Plan establishes a methodology for determination of reimbursement rates for HIV nursing facilities, operated exclusively for persons with human immunodeficiency virus (HIV) that causes acquired immunodeficiency syndrome (AIDS). Subject to limitations prescribed elsewhere in this plan, a facility's reimbursement rate shall be determined by the Division as described in this plan. Any reimbursement rate determined, by the Division, that has been appealed in a timely manner shall not be final until there is a final decision. Federal financial participation is available on expenditures for services provided within the scope of the Federal Medicaid Program and made under a court order in accordance with 42 CFR 431.250.

(3) General Principles.

(A) Provisions of this reimbursement plan shall apply only to HIV nursing facilities certified for participation in the Missouri Medical Assistance (Medicaid) Program.

(B) The reimbursement rates determined by this plan shall apply only to services for HIV residents provided on or after December 1, 1995.

(C) The effective date of this plan shall be December 1, 1995.

(D) The Medicaid Program shall provide reimbursement for HIV nursing facility services based solely on the individual Medicaid eligible recipient's covered days of care, within benefit limitations as determined in subsections (5)(D) and (5)(M) multiplied by the facility's Medicaid reimbursement rate. No payments may be collected or retained in addition to the Medicaid reimbursement rate for covered services, unless otherwise provided for in this plan. Where third party payment is involved, Medicaid will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Services.

(E) The Medicaid reimbursement rate shall be the lower of:

1. The average private pay charge;

2. The Medicare (Title XVIII) rate, if applicable; or

3. The reimbursement rate as determined in accordance with sections (11), (12) and (13) of this plan.

(F) Medicaid reimbursements shall not be paid for services provided to Medicaid eligible recipients during any time period in which the facility failed to have a Medicaid participation agreement in effect. A reimbursement rate may not be established for a facility if a Medicaid participation agreement is not in effect.

(G) When a HIV nursing facility is found not in compliance with federal requirements for participation in the Medicaid program, Sections 1919 (b), (c) and (d) of the Social Security Act (42 USC 1396r), it may be terminated from the Medicaid program or it may have imposed upon it an alternative remedy, pursuant to Section 1919 (h) of the Social Security Act (42 USC 1396r). In accordance with Section 1919 (h)(3)(D) of the Social Security Act, the alternative remedy, denial of payment for new admission, is contingent upon agreement to repay payments received if the corrective action is not taken in accordance with the approved plan and timetable. It is also required that the HIV nursing facility establish a directed plan of correction in conjunction with and acceptable to the Division of Aging.

(H) Upon execution of a Medicaid participation agreement, a qualified facility not previously certified for participation in the Medicaid Program shall be assigned a provider number by the Division. Facilities previously certified shall retain the same provider number and interim or prospective rate regardless of any change in ownership.

(I) Regardless of changes in control or ownership for any facility certified for participation in the Medicaid Program, the Division shall issue payments to the facility identified in the current Medicaid participation agreement. Regardless of changes in control or ownership for any facility certified for participation in Medicaid, the Division shall recover from the entity identified in the current Medicaid participation agreement, liabilities, sanctions and penalties pertaining to the Medicaid Program, regardless of when the services were rendered.

(J) Changes in ownership, management, control, operation, leasehold interest by whatever form for any facility previously certified for participation in the Medicaid program at any time that results in increased capital costs for the successor owner, management or leaseholder shall not be recognized for purposes of reimbursement.

(K) A facility with certified and non-certified beds shall allocate allowable costs related to the provision of HIV nursing facility services on the cost report, in accordance with the cost report instructions. The methods for allocation must be supported by adequate accounting and/or statistical data necessary to evaluate the allocation method and its application.

(L) Any facility which is involuntarily terminated from participation in the Medicare Program shall also be terminated from participation in the Medicaid Program on the same date as the Medicare termination.

(M) No restrictions nor limitations shall, unless precluded by state plan, be placed on a recipient's right to select providers of his/her own choice.

(N) The average Medicaid reimbursement rate paid shall not exceed the average private pay rate for the same period covered by the facility's Medicaid cost report. Any amount in excess will be subject to repayment or recoupment or both.

(O) The reimbursement rates authorized by this plan shall be reevaluated at least on an annual basis in light of the provider's cost experience to determine any adjustments needed to assure coverage of cost increases that must be incurred by efficiently and economically operated providers.

(P) Covered supplies, such as, but not limited to, food, laundry supplies, housekeeping supplies, linens, medical supplies, must be accounted for through inventory accounts. Purchases shall be recorded as inventory and shall be expensed in the fiscal year the items are used. Inventory shall be counted at least annually to coincide with the facility's fiscal year or the end of the cost report period, if different. Expensing of items shall be recorded by adding purchases to the beginning period inventory and subtracting the end of the period inventory. This inventory control shall begin the first fiscal year ending after the effective date of this plan.

(Q) Medicaid reimbursement will not be paid for a Medicaid eligible resident while placed in a non-certified bed in a HIV nursing facility.

(R) All illustrations and examples provided throughout this plan are for illustration purposes only and are not meant to be actual calculations.

(S) Each state fiscal year the Department shall submit to the Office of Administration for consideration a budget item based on the HCFA Market Basket Index for Nursing Homes representing a statistical measure of the change in costs of goods and services purchased by HIV nursing facilities during the course of one year. Each year, an amendment to section (13)(A) of the state plan will be filed that will contain the specific details of the trend approved for that year, including the amount, basis and effective date of the trend.

The submission of the budget item by the Department has no correlation to determining the costs that are incurred by an efficiently and economically operated facility. Any trend factor granted shall be applied to the patient care, ancillary and administration cost components.

(4) Definitions.

(A) Additional Beds. Newly constructed beds never certified for Medicaid or never previously licensed by the Division of Aging.

(B) Administration. This cost component includes the following lines from the cost report version MSIR-1 (3-95): lines 111-131, 133-149, 151-158.

(C) Age of Beds. The age is determined by subtracting the initial licensing year from 1995 or the current year, if later.

(D) Allowable Cost. Those costs which are allowable for allocation to the Medicaid Program based upon the principles established in this plan. The allowability of costs shall be determined by the Division of Medical Services and shall be based upon criteria and principles included in this plan, the Medicare Provider Reimbursement Manual (HIM-15) and GAAP. Criteria and principles will be applied using this plan as the first source, the Medicare Provider Reimbursement Manual (HIM-15) as the second source and GAAP as the third source.

(E) Ancillary. This cost component includes the following lines from the cost report version MSIR-1 (3-95) : lines 71-89, 91-100.

(F) Asset Value. The asset value of $32,723 per bed is used in calculating the Fair Rental Value System. The asset value consists of a bed cost and a land cost. The bed cost was based upon the national average cost of a nursing facility bed, without land cost, adjusted for the city index for Kansas City and St. Louis utilizing the 1994 R.S. Means Building Construction Cost Data. The land value was based upon a study of land costs for nursing facilities being approved for construction by the Certificate of Need program in Missouri.

(G) Average Private Pay Rate. The usual and customary charge for private patient determined by dividing total private patient days of care into private patient revenue net of contractual allowances and bad debt expense for the same service that is included in the Medicaid reimbursement rate. This excludes negotiated payment methodologies with State or Federal agencies such as the Veteran's Administration or the Missouri Department of Mental Health.

(H) Capital. This cost component will be calculated using a Fair Rental Value System. The fair rental value is reimbursed in lieu of the costs reported on lines 102-109 of the cost report version MSIR-1 (3-95) except for amortization of organizational costs.

(I) Capital Asset. A facility's building, building equipment, major moveable equipment, minor equipment, land, land improvements, and leasehold improvements as defined in HIM-15. Motor vehicles are excluded from this definition.

(J) Capital Asset Debt. The debt related to the capital assets as determined from the desk audited and/or field audited cost report.

(K) Ceiling. The ceiling is determined by applying a percentage to the median per diem for the patient care, ancillary and administration cost components. The percentage is 120% for patient care, 120% for ancillary and 110% for administration.

(L) Certified Bed. Any HIV nursing facility bed that is certified by the Division of Aging to participate in the Medicaid Program.

(M) Change of Ownership. A change in ownership, control, operator or leasehold interest, for any facility certified for participation in the Medicaid Program.

(N) Cost Components. The groupings of allowable costs used to calculate a facility's per diem rate. They are patient care, ancillary, capital and administration. In addition, a working capital allowance is provided.

(O) Cost Report. The Financial and Statistical Report for Nursing Facilities, required attachments as specified in paragraph (10)(A)8. of this plan and all worksheets supplied by the Division for this purpose. The cost report shall detail the cost of rendering both covered and non-covered services for the fiscal reporting period in accordance with this plan, cost report instruction and on forms or diskettes provided by or as approved by the Division or both.

(P) Databank. The data from the desk audited and/or field audited rate setting cost report for HIV nursing facilities.

(Q) Department. The Department, unless otherwise specified, refers to the Missouri Department of Social Services.

(R) Desk Audit. The Division of Medical Services' or its authorized agent's audit of a provider's cost report without a field audit.

(S) Director. The Director, unless otherwise specified, refers to the Director, Missouri Department of Social Services.

(T) Division of Aging. The Division of the Department of Social Services responsible for survey, certification and licensure as prescribed in Chapter 198 RSMo.

(U) Division. Unless otherwise specified, Division refers to the Division of Medical Services, the Division of the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) Program.

(V) Entity. Any natural person, corporation, business, partnership or any other fiduciary unit.

(W) Facility Asset Value. Total asset value less adjustment for age of beds.

(X) Facility Fiscal Year. A facility's twelve (12) month fiscal reporting period covering the same twelve (12) month period as its federal tax year.

(Y) Facility Size. The number of licensed HIV nursing facility beds as determined from the desk audited and/or field audited cost report.

(Z) Fair Rental Value System. The methodology used to calculate the reimbursement of capital.

(AA) Field Audit. An on-site audit of the HIV nursing facility's records performed by the Department or its authorized agent.

(BB) Generally Accepted Accounting Principles (GAAP). Accounting conventions, practices, methods, rules and procedures necessary to describe accepted accounting practice at a particular time as established by the authoritative body establishing such principles.

(CC) HCFA Market Basket Index. An index showing nursing home market basket indexes. The index is published quarterly by DRI/McGraw Hill. The table used in this plan is titled "DRI Health Care Cost - National Forecasts, HFCA Nursing Home without Capital Market Basket."

(DD) HIV Nursing Facility. Any facility licensed under Chapter 198 RSMo granted a Certificate of Need under 197.319 RSMo (1994) and certified by the Division of Aging.

(EE) HIV Nursing Facility Resident. A person that resides in a HIV Nursing Facility that has the HIV that causes AIDS.